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ABSTRACT

These proceedings consist of the texts of eight papers presented at a conference on patient education. Included in the volume are the following conference presentations: "An Educational Framework in the Ambulatory Care Setting," by Jeannette J. Simmons; "The Status of Education in Ambulatory Care: A Report of the American Hospital Association," by Elizabeth Lee; "Compliance: Solving a Problem in a Busy Emergency Room," by Judy Best; "Patient Education: A Better Way to Achieve Compliance in the Ambulatory Care Setting," by Susan Resnik, Eric Delson, and Alice Forster; "Selecting and Using Pre-Packaged Health Education Programs," by Marjorie F. Goldstein; "Preparing Families to Help Older People," by Ann Miles; "Project Upbeat: A Model for Cardiac Patient Education," by Audrey R. Gotsch; and "Pinpointing the Message to Achieve Compliance," by Francis J. Santora. (MN)

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PATIENT EDUCATION:

A BETTER WAY TO ACHIEVE COMPLIANCE IN THE AMBULATORY CARE SETTING

Proceedings from a conference held May 29, 1981
at the Mount Sinai School of Medicine

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The New York City Consortium for Patient Education

CE039563

PATIENT EDUCATION: A BETTER WAY TO ACHIEVE COMPLIANCE IN THE AMBULATORY CARE SETTING

PROCEEDINGS FROM A CONFERENCE HELD MAY 29, 1981,
AT THE MOUNT SINAI SCHOOL OF MEDICINE

EDITED BY:

NICHOLAS GALLI
ANNA SKIFF
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MOUNT SINAI SCHOOL OF MEDICINE
of The City University of New York
FIFTH AVENUE AND 100TH STREET • NEW YORK, N.Y. 10029

May 1982

Dear Colleagues:

As evidence mounts concerning the usefulness of patient education in improving patient compliance with therapeutic regimens, steps must be taken to insure that quality patient education becomes part of every hospital's care plan. It is my hope that the efforts of the New York City Patient Education Consortium will tangibly improve patient education and that this first conference on patient education and its proceedings will be useful to all health professionals.

Mount Sinai Medical Center is proud to support the New York City Patient Education Consortium through logistic help and staff time, and wishes all health professionals involved in fostering patient education programs good luck in their endeavors.

Cordially,

Thomas C. Chalmers, M.D.
President and Dean
Mount Sinai School of Medicine

MOUNT SINAI SCHOOL OF MEDICINE
of The City University of New York
One Gustave L. Levy Place • New York, N.Y. 10029

Brookdale Center For Continuous Education

May, 1982

Dear Colleagues:

The First Annual Patient Education Conference sponsored by the New York City Patient Education Consortium and by Mount Sinai School of Medicine's Brookdale Center for Continuous Education has helped to launch a program to improve patient education in New York City. This conference and its proceedings represent untold hours of work by consortium members, as well as their commitment to quality patient education.

From this first general, introductory conference, the Consortium plans to offer additional conferences focusing on specific skills for patient educators, and also plans to offer support services to groups wishing to improve patient education. For more information about these plans, call Jim Corry, Chairman of the New York City Patient Education Consortium, at 650-6737, or write to him c/o the Brookdale Center for Continuous Education, Mount Sinai School of Medicine.

I join with Dr. Chalmers, President and Dean of Mount Sinai School of Medicine, in wishing you good luck in your efforts to provide quality patient education in New York.

Yours sincerely,

SK Elster

Samuel K. Elster, M.D.
Director
Dean for Continuous Education

PROLOGUE

In February 1979, several hospital based health educators in the New York metropolitan area met to discuss common concerns, interests and problems related to patient education.

Soon after the meeting, a colleague from the N.Y.C. Health Department informed some members of the group of a desire by nurses in the ambulatory care units of municipal hospitals for training to facilitate patient adherence with prescribed medical regimens. The group now expanded to include twenty individuals representing a score of agencies all concerned with health/patient education, decided to accept the challenge of developing a training program and proceeded to investigate more fully the need for a "How to" conference in patient education.

As a first step, the group, (which came to be called The Consortium for Patient Education), formed an ad hoc committee to assess the need for and interest in learning more about educational intervention techniques among health care providers. A one page questionnaire was devised for this purpose. Each of the members of the Consortium was asked to administer the questionnaire to persons from different disciplines in the institutions where they worked. Within six weeks, this task was completed. An analysis of the data corroborated our impression that health care providers, across a wide range of disciplines, wanted to learn more about how to facilitate medical regimen adherence in their patients. A continuing education conference appeared to be appropriate and planning got underway for a conference entitled, "Patient Education: A Better Way To Achieve Compliance."

The Consortium members developed a one day, three part conference.

Phase one of the conference had two nationally known persons place the problem of achieving compliance in theoretical and national perspectives. The first provided a theoretical framework for developing educational programs in clinical settings. The second speaker presented the status of patient education programs in ambulatory care based on preliminary findings from a nationwide study.

Phase two of the program featured six field tested education programs reflecting the diversity and scope of problems facing workers in clinical settings. These programs included:

* "A Simple Way To Achieve Compliance: Solving a Problem in a Busy Emergency Room" - (an example of education for handling a simple time limited condition devised and carried out by a community hospital)
* "A Discussion of a Chronic Disease Model: The Plan and the Reality" - (an example of education about a serious chronic condition nationally produced and implemented)
* "Pinpointing the Message to Achieve Compliance" - (an example of education about an acute communicable disease in the outpatient clinic)
* "Project Upbeat: A Model for Cardiac Care Education" - (an example of a university medical center demonstration project being tested in community hospitals)
* "Preparing Families to Help Older People" - (an example of health agency community outreach efforts)
* "Selecting and Using Prepackaged Health Education Programs" - (advice on using pre-packaged materials)

The conference concluded with workshop sessions in which the conference participants could interact directly with those who had presented case reports. This format permitted members of the audience to seek answers for and to probe specific questions for details of particular interest to them.

This monograph includes the collection of papers presented at the Patient Education Conference on May 29, 1981, at the Mount Sinai School of Medicine. It is hoped this conference will be the first in a series of conferences on the subject. The monograph represents tangible evidence of the commitment of the Patient Education Consortium to extend and strengthen patient education in metropolitan area health care services. The monograph will serve also as a resource to those who attend future conferences. Further, the document should be useful to those generally interested in improving the field of patient education.

May 1982
New York City

Nicholas Galli
Anna Skiff
Diane Urban
James Corry

ACKNOWLEDGEMENTS

We wish to acknowledge and sincerely thank the following groups and individuals without whose support, neither the conference, proceedings, nor perhaps the Patient Education Consortium itself would exist. Thanks to Dr. Samuel K. Elster, Dean of the Page and William Black Post-Graduate School of Medicine and Director of the Brookdale Center for Continuous Education at Mount Sinai School of Medicine (CUNY) who provided and continues to supply encouragement and financial support for the advancement of patient education. Dr. Elster, through the kind generosity of the Brookdale Foundation, has supported the patient education conference, the proceedings document, and the monthly meetings of the Patient Education Consortium with financial, administrative and logistical resources. We are deeply grateful. Thanks also to the staff at Mount Sinai who worked so hard to provide an enjoyable meeting setting.

The American Hospital Association deserves special thanks for sending Elizabeth Lee, their excellent advocate for patient education, as a speaker. They also paid for the expenses of our outstanding key note speaker - Dr. Jeannette Simmons, and for this we are very appreciative.

The conference would not have been possible without the hard work of the consortium members who were kindly supported and encouraged in their efforts by their employers. These people and their agencies include: Stephanie Lederman, American Red Cross of Greater New York, Blossom Duckler, Health Insurance Plan of Greater New York, Audrey Gotsch, College of Medicine and Dentistry of New

Jersey, New Jersey Medical School, Office of Primary Health Care Education, Emily Glazer, Lutheran Medical Center, Department of Family Practice, Randi Moskowitz, Memorial Sloan-Kettering Cancer Center, Office of Cancer Communication, Sylvia Wholeness, Montefiore Hospital and Medical Center, Department of Nursing, Susan Resnik, National Hemophilia Foundation, Lois Siegel, New York City Department of Health, Bureau of Public Health Education, Frank Santora, New York City Department of Health, Office of Venereal Disease and Control Education, Ann Miles, New York University Medical Center, Division of Gerontology, Office of Urban Health Affairs, Dan Lombardo, St. Clare's Hospital and Health Center, Department of Educational Advancement, Maria Lagudis, St. Vincent's Hospital and Medical Center, Department of Educational Advancement, L. Virginia Fernbach, Society for Public Health Education, Tri-State Chapter, Anna Skiff, United States Public Health Service Hospital.

We especially acknowledge Anna Skiff who did an excellent job as moderator of the conference, and Nick Galli who served as Chairperson of the Patient Education Consortium.

Special thanks go to the speakers at the conference including: Jeannette J. Simmons, DSc, Elizabeth Lee, RN, MSN, Judy Best, RN, MA, Susan Resnik, MSAM, Eric Delson, RN, MSN, PNP, Alice Forster, RN, BS, Marjorie Goldstein, MS, MPH, Ann Miles, MPA, Audrey Gotsch, DrPH, and Frank Santora, MS.

We also wish to acknowledge the exhibitors for taking the time to share information about their various products and services.

Lastly, we wish to thank the dedicated patient educators who attended the conference for their interest, questions, and criticisms of the conference. The criticisms will be very useful in shaping future conferences, and we thank

those individuals who took the time to share their concerns and needs about continuing professional development.

Nicholas Galli

Anna Skiff

Diane Urban

James Corry

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"AN EDUCATIONAL FRAMEWORK IN THE AMBULATORY CARE SETTING"

Jeannette J. Simmons, DSc
Lecturer, Department of Preventive
and Social Medicine
Harvard Medical School

This paper presents an overview of the research and theory relative to patient compliance. Of particular interest will be remarks concerning establishing and maintaining rapport between providers and patients.

EDUCATION OR COMPLIANCE AS A GOAL OF PATIENT EDUCATION?

The title of this day-long course is "Patient Education: A Better Way To Achieve Compliance in the Ambulatory Care Setting". I would like to start by saying that education is not only a better way but in my opinion the only way. This opinion is based on a consideration of Kelman's (1) description of how to bring about behavior change. He distinguishes among behavior change which results from compliance, identification and internalization. Compliance relates to behavior change which occurs because the individual seeks a reward or punishment not because of belief in the behavior. This behavior tends to be performed only under surveillance. Hence in some inpatient situations you can have behavior carried out under compliance conditions.

The second way that Kelman describes bringing about change is through "identification". In this process the individual accepts the change through imitating the behavior of another person to gain this person's approval. There

is some of this role modeling in patient education settings; however, when the patient leaves the setting and goes about carrying out the responsibilities without the role model present, or with different circumstances surrounding the behavior, the patient can easily stop the new behavior because he has not accepted the content.

The third method to bring about change is labeled by Kelman as "internalization". This is when the individual decides to act because he perceives the action as being relevant and credible. The action is then incorporated into his value system and he recognizes his perception in keeping with the newly valued behavior. To accomplish this type of change requires greater involvement of the individual in determining what and how a behavior can be undertaken. Hence education is, in my opinion, the only way to obtain compliance for on-going, personal, independent actions which are associated with a therapeutic regimen in an ambulatory setting. Along with this perspective from social psychology I would like for you to consider what different connotations are given by the terms compliance and education. The dictionary states that to comply connotes acquiescence and passivity while to educate connotes liberation, understanding, and the formation of one's own conclusions. It is within this context of education that I want to present my thoughts on patient education and compliance.

PATIENT EDUCATION COMES OF AGE

In the last decade, the literature on patient compliance has become very extensive. Last year the National High Blood Pressure Institute published a 268 page book which reviews the literature and assesses the key trends in the research findings. Within this body of literature there are a number of studies

which describe physician/patient interactions and educational strategies that have been used to increase the level at which individuals accept and build into their own patterns of thinking and acting the recommended behaviors related to the maintenance and improvement of their health. The state-of-the-art is described as follows by one of the authors of this publication (2):

> "This review has presented evidence that several sorts of interventions in the context of clinical-patient interaction brings benefits for both behavioral compliance and clinical outcomes. The evidence seems to justify continued carefully evaluated interventions in the clinician-patient relationship aimed at improving compliance. At the same time there is still the need to learn more about the specific elements that make these strategies work."

Since you all are responsible for some aspect of the clinician/patient encounter, I will focus my thoughts on improving communications in this interaction. Other program participants will describe specific educational programs from the planning stage through evaluation.

Now, will each of you think of a specific setting in which you are educating patients and throughout my presentation "translate" the concepts and suggestions to ways they could be applied to that setting. You obviously may also elect to reject them!

COMMUNICATIONS: THE KEY INGREDIENT IN AN EDUCATIONAL ENCOUNTER

Let me start with a transparency which identifies the reasons I believe it is essential for a health care provider to develop effective communications with a patient.

EFFECTIVE COMMUNICATION

IS NECESSARY TO:

Elicit information for accurate diagnosis

(including educational needs)

Formulation of the Treatment Plan

(relevant, credible and feasible to the patient)

Monitoring Follow-up and Referrals

(what is the patient doing, not doing, and why)

Determining what needs to be taught

(knowledge, skills, and their sequence)

Effective communication is essential throughout the entire continuum of patient care.

Next let us consider the essential elements involved in creating a learning environment in the interaction which takes place between the clinician/patient.

UNDERSTANDING THE PSYCHOLOGICAL SET OF THE LEARNER

First, one must proceed from where the learner is, not where the teacher is, in concern, knowledge level and thought patterns. It is where the learner is that should form the basis for selecting the educational strategy. At the beginning of the encounter, the clinician needs to get the patient to tell you in his words, what is the problem, what are the concerns, what has been experienced with this illness or condition, what he has already done, what family members, friends, others say about it, and who has already given what advice.

When you begin to listen to how the patient describes what is going on, what words they use (nouns and verbs vs. explosive adjectives and adverbs) and the ordering of their concerns, you are picking up clues about their frame of reference

for this condition as well as their vocabulary. In addition, you can gain insight into the individual's perception of the problem, relationships with others, and the associations the individual has with illness. The psychological literature (3) on perception tells us that when we look at pictures, hear words, see a new situation, we immediately focus on some one object or idea that has relevance and significance to us at that time. What we "attend to" sets the pattern of how we develop our "script". Let me cite an example of this theoretical construct from my use of it in a class of health professionals.

The picture used in the class "experiment" is a scene on the Navajo Reservation in which a physician, two Navajo Medicine Men, a grandmother, and a nurse are gathered around an infant who is receiving an IV. Members of the class (physicians, social workers, dentists, behavioral scientists, educators) always start their interpretations of what is happening in this scene from a variety of professional and personal experiences. Their "scripts" interpreting what is happening thus produce many variations. In one class the influence of an immediate personal experience produced a most dramatic response.

A young physician arrived in class a few minutes late because he had been at the hospital where his wife had just delivered twin babies. The babies had been placed in an incubator and he was not allowed in the room to see them - he had to view them through a window. When he described what he saw in the Navajo picture his words tumbled out in an excited and agitated concern about the baby - the baby - the baby. He had many interpretations of what was going on in relation to the baby but the rest of the scene was left undescribed.

When you get a patient at the outset to talk about their problem, what they have done about it, what they think might be done about it, and their

expectations, you are eliciting their frame of reference as to how they view their illness and their responsibilities. This then becomes the basis for discussing the diagnosis, treatment plan and follow-up.

The challenge is (although it's much easier for me to say this than for me to do it or for you to do it) to be able to listen and creatively pick out the clues that will help you to communicate at the level of knowledge, interest, concern, and patterns of thinking of that person. This is equally applicable to group learning which is another important methodology for patient education. In relation to the group method to elicit information from the patient's perspective, there is now appearing in the field a marketing technique called the "focus group". In this technique, the leader is instructed to start by getting members of the target audience (buyers) to define what's on their agenda and what's their concern. The content of the session is analyzed for how individuals say things as well as what they say. The leader sets the stage so that no remark will be considered ridiculous, inappropriate or way out. Everything is recognized as having meaning and the object of the group setting is to stimulate interactions.

ESTABLISHING RAPPORT AND A CLEAR COMMUNICATION CHANNEL

In health education we have used Lewin's (4) group process concepts to do this. We know that when one person starts describing a problem, solution, etc., it will trigger thoughts and comments by others, which leads to the development of ideas which are far more expansive than those obtained in one-to-one communications. More anxieties, probing questions, and ways of thinking about oneself can be elicited through this method.

Two health education professionals who have found ways to help this process along are Anna Skiff and Marjorie Goldstein, at Staten Island USPHS Hospital.

They worked with the personnel in the Out-Patient Department to develop a very simple questionnaire which allows the patient to put down some thoughts before he visits the physician. The questionnaire covers such items as:

> Why are they coming? What is their diagnosis? What medications are they on? What are they doing? What do they expect to happen in this visit?

The results of this effort shows that with a one-page questionnaire, which is given to the doctor along with the chart, the conversation between the patient and the doctor can be more quickly initiated. The information alerts the doctor to the thoughts and concerns that the patient has and hence it is possible to more effectively focus the visit and accomplish more in less time.

I have used this same questionnaire with the staff of the Out-Patient Department at Maine Medical Center and found that it also elicited from the patient surprise that the health care provider wanted to know these things. Within this response was an implication that "I didn't know you cared this much about me." So here is a simple tool and procedure which can be used as a method of engaging the mind and thoughts of the patient who is sitting in the waiting room which will save time and produce some very effective results. It does initiate communication with a patient that has relevance and provides a frame of reference and vocabulary for the provider to use in developing an effective dialogue and interaction.

COMMUNICATIONS THEORY: TIPS FOR SUPPRESSING INTERFERENCE IN DIALOGUE, USE OF PRINTED MATERIALS, AND AUDIOVISUAL MEDIA.

Others on the program will give examples of how they are applying these principles to develop more effective communications. Let me quickly sketch out

some additional thoughts about this encounter and how you as the clinician can work with the patient. First, let me summarize by stating: Listening is not simply hearing; it is hard work. We have to interpret what we hear, we have to evaluate it, and then we have to respond to what we've heard. Both individuals in the communication process have to do this. Studies show that most of us only listen at a 25% level of efficiency. If I'm to get my messages through to you today, then I need to repeat the points at least 4 or 5 times. Right? For your part, let me say that it helps not to get too comfortable and drift off into other thoughts and it helps to eliminate distractions.

Another way of examining the communication process is presented in a model developed by Berlo (5). It appears on the next transparency:

BASIC COMMUNICATION MODEL

Sender Codes — Selects Channel — Message — Receiver Decodes

Feedback

In this model you are directed toward the recognition that a message must be decoded - that is interpreted by the receiver and feedback is given, the sender can determine what parts of the message "got through, and what, if any, distortions occurred." The model also indicates that the channel selected can have "interference" and here the message does not get through. In the health care setting this interference can be an anxiety state in the patient, distractions and/or noise in the setting, etc. Once again, if the sender does not pause or expect feedback on his messages, there is no way to know what the receiver has heard nor how it has been decoded.

Remember that the amount of time it takes for someone to take in the ideas and words that come in phrases throughout a sentence, and then decide how to program these messages into the individual's thought processes, is obviously longer than the time it takes for the speaker to give the message. The speaker often has already gone on to the next set of phrases and ideas before the first set has been decoded. So it is important to have frequent pauses in one's communication, to allow the person to say that they have been hearing, what questions they have. This process provides time for decoding and imprinting within the receiver's mind the messages given in the communications. It is important at the outset to put the patient at ease; expect interruptions and feedback on messages. Also as I have stated earlier, the communication should start with the patient, so you have the assignment of listening, decoding and picking up clues of how to feedback relevant information for the thought processes of the patient. You are seeking answers to: what are their concerns, expectations, frame of reference, about their presenting illness or on-going management of a health condition. Keep this basic model in mind when communicating with anyone, including other health professionals.

In terms of written materials we use this process in pretesting. When you take your message content, format, and sequencing of ideas out to members of the target audience and obtain feedback, you want to know how the written message is understood and interpreted and what is missing from the viewpoint of the reader. The members of the intended audience give you feedback on what the pictures and words mean to them and what they think the ideas as a whole mean. Often this is very different from the writer's intentions. Cecilia and Len Doak (6) applied both the SMOG (7) and CLOSE (8) Tests to patient education materials used in a Public

Health Service (PHS) Hospital out-patient clinic. They found most of the material was at 10th grade level or above and some at the 16th grade level. This is far beyond the average reading and comprehension level in the US population.

The Doaks also transcribed some verbal messages given by PHS Hospital staff members. They found that health professionals tended to use less complicated sentences and more commonly used words in their oral communications than in their written messages.

BODY LANGUAGE AS "NOISE" OR INTERFERENCE IN COMMUNICATIONS

Nonverbal communication also has tremendous impact on the patient. What do we say with our facial expressions, body movements and other behaviors? Most of you have no doubt covered this aspect of communication in your educational preparation. However, I would like to suggest a new technique that has recently appeared in the literature (9). In a program for staff development at John Hopkins University, a 45 minute, 16mm film was produced to measure the viewers nonverbal sensitivity. Medical residents and attending physicians were studied to determine how they were able to pick up the nonverbal clues which appear in the film from both the patient and the clinician. The study then observed these physicians in their communications with patients to determine what association there is between clinician's level of ability to observe non-verbal clues and his ability to use this skill in his own communications with patients. They found a strong relationship between the ability to recognize non-verbal clues from others and their own use of non-verbal clues. This is an instrument which can be used to increase the insight clinicians have about their non-verbal behavior and the recognition of non-verbal messages from their patients and how these effect the interactions in the relationship. If you are

interested and feel comfortable about looking at your behavior, you could agree to have one or more of your encounters put on videotape and analyzed. So it's mirror-mirror on the wall, who's the fairest of them all? How do I really do?

Some of the non-verbal behaviors of clinicians that studies show "turn off" patients are related to facial expressions which suggest hostility, disgust or disinterest. Also, a patient can have a feeling of not being considered important if the following happens without an explanation: The clinician is interrupted by telephone calls, is called out of the room, is writing while the patient is talking, looks through material on desk, etc. Another error can be made if one assumes that a person understands or is following a trend of thought because the individual shakes his head; this cue needs to be checked out.

DESIGNING THE CLEAREST EDUCATIONAL ENCOUNTER

In the literature there are many studies that suggest important considerations in deciding how to design and deliver a message. I will cite some of them.

In clinician/patient communication a large percentage of the time is developed by the clinician talking about the disease, its cause and effects. An overload of ideas occurs through this presentation - so that when the essential points of what the individual is to do about the problem is presented, the patient's mind is too full to take in the most important points. Ley's (10) studies show that when the order of these ideas is reversed, the patient's knowledge and adherence improves.

Studies directed at memory have shown that the maximum number of new items that a person can remember in a message is seven and most remember or only retain three or four. Under the anxiety state of an illness encounter, the performance of the patient is likely to be even lower.

Many diagnostic procedures and follow-up responsibilities require more than three or four items. Thus the clinician needs to use written messages, check lists, and staged visits to cover different aspects of illness management. Obtaining feedback from a patient during the visit can help to clarify and correct any misinterpretations. It is therefore important to plan the way you present the essential advice. One must think in terms of what's the immediate thing the patient needs to do and is ready to act upon; what's the provider's overriding concern of needed action; how do these two points of view come together? What negotiation and communication is needed to bridge this gap? As discussed previously, whenever possible, priority should be given to the learner's frame of reference and readiness. Supporting materials are more than just checklists. If the person wants to read more about the condition, or they feel their spouse, friend, employer, will ask questions and want to know more, then supplementary sources should be made available (written, A-V, resource persons, classes). The patient should be told that on the next visit the clinician would like to hear about what the patient has read, what questions he has been asked, and what questions all of this has raised with that patient.

Learning theory stresses the need for reinforcement and that does not mean just repeating a message. Success is more likely when an idea is presented in a variety of ways because individuals learn through different media, have different ways of thinking and acting. When patients have an opportunity to interact with different health professionals, they have a greater likelihood of matching up and/or reinforcing a pattern of learning congruent with theirs. Patients vary in how they relate to different health professionals and thus exhibit different listening patterns and willingness to accept ideas and recommend-

ations. The nature of the relationship makes a difference on how patients obtain, maintain and utilize information offered.

COMPLIANCE THROUGH EDUCATION

Studies (11, 12, 13, 14) have shown that a combination of interventions help achieve a higher level of adherence. These include: counseling interviews; written instruction, exit interview (review what clinician told them and make very explicit what they are to do); involvement of a support system; self-recording (diary-write down what happens so we can talk about it); identifying cues related to behavior; group discussion; contingency contracting; and performance feedback.

An in-depth observation, record review and interview study conducted in an ambulatory care setting by Svarstad (15) found that the following factors in the doctor/patient interaction influenced the level of adherence achieved:

1. The patient's perception of the physician's approachability (can they talk to him, ask questions)
2. The physician's justification of the recommended actions (does he state why these actions are important to the treatment and outcome)
3. The level of compliance the physician expects (does he indicate this to the patient)
4. The use of influence of medical authority on a limited basis ("I want you to take the medicine", not "we can try the medicine")
5. Demonstrate that the patient's behavior and responses to therapy are being monitored (check up at next visit)

In addition Svarstad found that system disruptions produced a number of

situations where a doctor thought he had carried out a certain procedure or covered certain points with the patient but the tape recording and interview found this not to be so.

SUMMARY

The other presentations today will offer you additional ideas and strategies for improving patient education and increasing adherence. So I will close with the same opening; the literature says that the really difficult part for the person providing patient education is how they can approach this responsibility in a resourceful way and with great patience in many situations.

It may sound like patient education has to be very time consuming; however, studies show that the more time the patient spends with the provider explaining the illness condition and recommended action, often less education is taking place. Extra time can be a signal that the clinician is in difficulty. Often this occurs when too many ideas and/or too much detail is being given about the illness for the patient to comprehend or remember. When the clinician tries to review what the patient needs to know, so many gaps exist that more time is spent repeating.

Careful planning is important. This includes determining what reinforcement mechanisms can be used and the need for utilizing a variety of educational methods to increase the prospect that the patient will learn what is necessary and agree to undertake the desired actions.

Finally, many of the clues you need to help you identify the specific concerns, beliefs and behaviors of the sub-populations you work with can be obtained by reading the literature about the characteristics of the sub-populations

you are working with; how they think about health and illness; what ways they describe symptoms and the treatment patterns they have experienced.

You can also talk with other persons who have worked with the members of these sub-populations. A great deal of insight has often been gained by these individuals. When a staff begins to share their knowledge and concerns, the culminative effect can be most significant.

Another important procedure is for you to go back over your own records, using a random sample, to determine the pattern of responses you have had to the recommendations you have made, and the outcomes of these actions. This procedure can increase your awareness of the magnitude and the determinants of non-compliance among your patients. You may find that you have not done routinely what you think you do. The Peer Standards Review Organization literature has many examples of these inconsistencies.

Finally, clinician/patient communication should be developed around the learner's frame of reference, careful thought given to the sequencing and timing of the educational content. Supporting materials should be used, and a variety of reinforcing strategies should be designed around the needs of the patient, the nature of the health problem and the complexities of the actions the patient must undertake.

All of the educational development is premised on a recognition that the patient has independence in decision-making and hence must be actively involved throughout the educational process.

REFERENCES

1. Kelman, H.C. "Compliance, Identification, and Internalization - Three Processes of Attitude Change," Journal of Conflict Resolution, Vol. 2:51, 1958.

2. Garrity, Thomas F. "Medical Compliance and the Clinician-Patient Relationship: A Review," Patient Compliance to Prescribed Antihypertensive Medication Regimens: A Report to the National Heart, Lung, and Blood Institute, USDHHS, PHS, NIH, No. 81 - 2101, October, 1980.

3. Krech, D. and Crutchfield, R.S. Theory and Problems in Social Psychology, New York: McGraw-Hill, 1962.

4. Lewin, K. Field Theory in Social Science, New York: Harper and Row, 1951.

5. Berlo, D.K. The Process of Communication, New York: Holt, Rinehart, and Winston, 1960.

6. Doak, L.C. and Doak, C.C. "Patient Comprehension Profiles: Recent Findings and Strategies," Patient Counseling and Health Education, 2 (3), pp. 101-106, Third Quarter, 1980.

7. McLaughlin, H.G. "SMOG grading - A New Readability Formula," J. Reading 12, 1969.

8. Holcomb, C. and Ellis, J.K. "The Cloze Procedure," Health Education 8-10, 1978.

9. DiMatteo, M.R., et al. "Predicting Patient Satisfaction from Physicians, Non-Verbal Communication Skills," Medical Care, 18 (4), pp. 376-387, 1980.

10. Ley, P. "Primary, Rated Importance, and the Recall of Medical Statements," J. Health Social Behavior, 13 (3), pp. 311-317, 1972.

11. Beckor, M. and Maiman, L. "Strategies for Enhancing Patient Compliance," J. Community Health, 6 (2), pp. 113-135, Winter, 1980/

12. Levine, D.M., Green, L.W., et al. "Health Education for Hypertensive Patients", JAMA, 241, pp. 1700-1703, 1979.

13. McKenney, et al. "The Effect of Clinical Pharmacy Services on Patients with Essential Hypertension," Circulation, 48, pp. 1104-1111, 1973.

14. Logan, A.S., et al. "Worksite Treatment of Hypertension by Specially Trained Nurses: A Controlled Trial," Lancet II, pp. 1175-1178, 1979.

15. Svarstad, B. The Doctor-Patient Encounter: An Observational Study of Communication and Outcome. Unpublished doctoral dissertation, University of Wisconsin, Department of Sociology, 1974.

THE STATUS OF EDUCATION IN AMBULATORY CARE: A REPORT OF THE AMERICAN HOSPITAL ASSOCIATION

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Elizabeth Lee of the American Hospital Association chose not to submit a paper for the proceedings. The editorial committee, however, has noted these major points from her presentation:

* The American Hospital Association, funded by a grant from the Bureau of Health Education, is studying the status of patient education in ambulatory settings and community settings. Specifically the grant is to:
    a. define the current status of patient education including barriers
    b. facilitate cooperation of the many organizations providing patient education and health education
    c. set up a dissemination and spot system and
    d. increase health education knowledge and skills.
* Since the study relies on input and feedback from practitioners, AHA appeals to you to provide your point of view as to what the issues are in health education and patient education.
* Some barriers that seem to be of concern to practitioners include:
    a. lack of funding
    b. lack of time
    c. lack of organized, defined programs (i.e., lack of structure)

d. inter-professional tensions and role-confusion about patient education

e. difficulty of providing interdisciplinary patient education

f. low knowledge level of staff about patient education

g. limited continuing education opportunities in patient education

h. great diversity of patients with their many needs.

* Some things that may help to overcome the barriers:

a. lobbying by American Hospital Association for administrative support of patient education

b. use of media

c. use of volunteers

d. creating guides to funding sources; helping facilitate reimbursement for patient education

e. facilitating cooperative efforts by many organizations.

* Some sources of information that are very useful to patient educators include:

a. Health Information Clearinghouse

b. Center for Health Promotion and Education at the Center for Disease Control

c. American Hospital Association

COMPLIANCE: SOLVING A PROBLEM IN A BUSY EMERGENCY ROOM

Judy Best, RN, MA, Health Education Consultant

This report demonstrates carefully and systematically, essential elements of sound program planning. It solves a presenting problem and shows how a simple evaluation can be carried out with important benefits for future programming.

ESTABLISHING PATIENT EDUCATION: THE CHALLENGE

In 1975 the American Hospital Association issued a statement entitled Health Education: Role and Responsibility of Health Care Institutions, which made quite clear that: "Hospitals have an obligation to promote, organize, implement, and evaluate health education as an integral part of health care." (1)

In spite of such strong urgings, many hospital administrators fail to support patient education on the grounds that its effects are too difficult to measure; for the most part the service is non-reimbursable, and since employees' time invested in such ellusive efforts cannot be measured against monetary gain, why invest in so-called "illness prevention" when hospitals stand to lose patient numbers and ultimately money.

Proven by many controlled clinical trials, well documented in the literature, and legally urged by governing hospital agencies, it fails to gain support on the institutional level. Thus, we have the patient education paradox: If it's so good, why isn't there more of it?

Increasing consumer awareness has provided us with tangible evidence that there is an increased willingness on the part of the patient population to learn

more about their bodies. Even though we are not equating a request for information with the process of learning, or the process of learning with a desire or willingness to modify behavior, more and more patients are asking about their health.

More and more government clearinghouses are being established to disseminate health information. Health insurance providers are publishing more and more patient education pamphlets as well as encouraging patients to seek a second opinion to assure proper and accurate treatment. Pharmaceutical houses, which previously provided literature aimed at the health professional, are more and more creating educational materials for the consumer.

The facts seem to be everywhere. The traditional "Who, What, Where, When, Why" and even the "How to" of patient education are self-evident. So the obvious question is: If the patient is asking for all this information and is demonstrating a willingness to modify behavior for improved health, why aren't there programs to address their needs.

A DEMONSTRATION PROJECT: ONE IMPORTANT STEP IN ESTABLISHING PATIENT EDUCATION

The answer to this question usually rests in the lack of administrative support. The solution rests in demonstrating that patient education is not a risk, threatening decreased patient numbers and therefore monetary losses, but rather is a productive tool which when properly implemented implies the potential result of appropriate and effective use of hospital services.

The following is an example of how such obstacles were addressed:

Our case study took place in a moderate-sized suburban community hospital which, by virtue of its geographic location, served the health needs of the middle to upper-middle class residents. In-patient services included acute

medical-surgical, maternity and pediatric. Out-patient services were devoted to the broad and comprehensive areas of rehabilitation. A family practice program provided services which might otherwise exist in a traditional clinic setting.

The administrative structure was listed as decentralized, but owing to an evolution from family-type management, all policy-making and programatic sanctions were synonymous with the Executive Office.

Traditionally, patient education had been the coveted domain of the nurse clinician. Consequently, formal patient education, that is programs available for general hospital staff use, did not exist, implying that the powerful privileged selectively addressed the educational health needs of the special or unusual patient.

Conversely, in the out-patient setting every health practitioner was involved in some personally-conceived type of patient/health education, but likewise no formally documented program existed.

In all cases, one fact was very clear: There was to be no "turf sharing" or "role merging". Compounded by lack of administrative support and no individual administrative power, the official role of patient educator became an anathema.

There seemed little hope for staking a claim for patient education until the Director of Ambulatory Services was asked to accept and supervise a student intern from a local college whose interest was health sciences. The student was requesting an opportunity to be assisted and supervised in designing a health demonstration program from which she could gather data to document the benefit of health education in the hospital setting.

The patient educator was asked to supervise the student, and the following events unfolded:

It was immediately realized that the program had to be established in the only area of administrative support: Ambulatory Services. It had to be designed in such a way that it would neither conflict with nor require the approval of nursing administration and further, would require no funding for audiovisual tools or equipment. It lastly required a short period for completion, due to the student's time limit of two months.

We hypothesized that providing a program which would demonstrate a benefit or a gain to the hospital would subsequently provide greater acceptability for future programming attempts.

The salient considerations were to solve a problem that cut across professional roles, and to define a location which would not remove instruction from the site of care where a patient would be most willing to receive and incorporate health information. This left one location - the Emergency Room; and one problem - inappropriate repeated use of the service. The key issue was to demonstrate the beneficial effect of compliance where otherwise preventable morbidity would result in the previously stated problem (misuse of Emergency Services).

We sought to select an illness or health disruption by using the following criteria. Was there a health disruption which was initially appropriate for emergency care? Would compliance reduce or eliminate inappropriate revisits for follow-up care during the course of recovery?

Two categories were initially isolated: 1) lacerations, and 2) fractures. The latter was eliminated as a choice because of its high degree of variability.

Since no screening was done at the time of registration to eliminate

inappropriate use of the service, all Emergency Room (ER) personnel were in agreement that considerable time could be saved in all sectors of ER staffing if laceration patients did what they were supposed to do: keep their wounds clean, and have sutures removed at the designated time.

Evidence of compliance was equated with the patient's adherence to a specific and prescribed regimen. Compliance indicators were defined as any actions taken on the part of the patient to assure expected wound healing, including the appropriate timing of suture removal. The program goal, which was to effect a change in patient behavior, was to be measured by a decreased use of emergency services for the removal of sutures and a treatment of wound infections.

Recognizing that there is a poor correlation between actual knowledge and behavior (as demonstrated by smoking cessation programs) we choose not to use knowledge as an evaluative measurement of program success. We also agreed not to evaluate if teaching was taking place but that learning was being accomplished, and therefore compliance would be a measurable behavior change in the target population.

The project was begun with a two-month retrospective audit of Emergency Room visits. A well-ratioed male/female population of 30+ patients over the age of 21 was easily isolated. No other demographic or qualifying criteria was imposed. Each patient was contacted by phone and asked the following questions:

1. Were you given any instruction regarding the care of your wound and told when to have the stitches removed?
2. Did you have any problem with your wound such as infection or delayed healing?
3. When did you have your stitches removed and where (ER, Doctor's Office)?

4. Did you find it necessary to seek medical care before your stitches were removed? If so, where did you go for this care?

Based on reports of the Emergency Room staff, it came as no surprise that there was a high incidence of infections, delayed wound healing, and inappropriate timing of suture removal.

There appeared a pattern of compliance barriers. Many patients reported no recall of instruction to keep wounds dry although many remembered being told to keep it clean. Further, since many of the ER physicians apparently were instructing patients to have their sutures removed in "about 10 days", many patients perceived this as a nonimportant aspect of their recovery.

The teaching content was designed with two patient objectives:

1. To provide the patient with an understanding of the healing process, and,
2. To prevent delayed wound healing as a result of complications.

The content was delivered both verbally and in written form. The written component was a simple description of wound healing, instruction for care consisting of do's and don'ts, and the warning signals of complications and what to do for follow-up with a local doctor.

Since patients are generally anxious at the time of acute care, they tend to block information about self care. Therefore, Emergency Room residents and nurses were requested to tell the patient that they were going to outline guidelines for wound care, formally verbalize the guidelines for wound care, and recap by stating that they had just instructed the patient in wound care and were there any questions.

Instructors were asked to make appropriate instructional connections:

If you do this...this is expected to happen. If you don't do this...this is expected to happen.

At the actual time of release from the Emergency Room, the unit clerk was asked to read the instructions to the patient, and if any questions were raised, to summon the attending nurse. The patient was then asked to sign that s/he has received formal instructions.

Sample comparisons were begun 15 days after the institution of the instructional program. Again patients were contacted by phone, and asked the same 4 questions. Population matching was satisfied when an equal number of patients had been contacted for post-instruction program follow-up.

Patients reported a marked decrease in infection, with appropriately anticipated wound healing time.

Since program evaluations were linked to decreased use of the Emergency Room for laceration complications and suture removal, success was demonstrated when it was validated that none of the 30+ patients returned to the Emergency Room for follow-up laceration care or suture removal.

CONCLUSION

In a purist sense, this program did not actually quantify "health measurement results." It quantified the effect of compliance related to the use of hospital services.

Since the evaluation of every program rests in the achievement of its goals, the program was rated as a clear success. It was thus proven on a small and simple scale that providing patient education and making a patient a partner in his self-care, ideally benefitted both the patient and the provider. Assuming that informed patients are more able to intellectually invest their energies

in self-care and preventative measures, the effect of compliance in health regimens can be demonstrated to be as much a benefit to hospitals who are concerned with appropriate use of their services as for patients who may require their use.

REFERENCES

1. American Hospital Association: "Hospitals Must Become Consumer Health Educators." P. 69.

PATIENT EDUCATION:
A BETTER WAY TO ACHIEVE COMPLIANCE IN THE AMBULATORY CARE SETTING

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This paper describes an educational guide for management of a serious chronic genetic disorder. It stresses the minimal essential information needed for coping with hemophilia and the importance of an interdisciplinary effort in educational planning and implementation. The content of the program was validated by health professionals, patients and their families. Use of this guide and teaching materials insures an ordered approach to teaching patients about hemophilia. Such an approach enhances the confidence of both the novice as well as the experienced professional, by conceptualizing major elements of management.

Editor's Note: This paper describes the history, development, advantages and use of a teaching guide for health care providers, patients and their families which was created by the Educational Resources Project of the National Hemophilia Foundation. Three health professionals - Ms. Susan Resnik, Director of the Educational Resources Project; Mr. Eric Delson, Hematology Nurse Clinician for

the New York-Cornell Medical Center, as well as Pediatric Nurse Practitioner; and Ms. Alice Forster, Hemophilia Nurse Clinician for the Mount Sinai Medical Center, discuss the project from the vantage point of: the project director; a practitioner who, in the field for many years, helped to develop the guidelines and now uses them; and a practitioner new to hemophilia care who didn't help to design the materials, yet uses them effectively.

Ms. Resnik: Because there are only between 20 and 40 thousand people (1 in 10,000 males) with hemophilia in the U.S. today, it is quite probable that many of you neither know what hemophilia is, nor are aware of current methods of care, nor have had occasion to work with it. Briefly then, I will define hemophilia so that you can share our frame of reference as we present a discussion of our educational program.

DEFINITION

Hemophilia is a congenital clotting disorder usually affecting males; women are the carriers. For both discussion and funding purposes, it is considered a genetic and chronic disorder. Bleeding is usually spontaneous, internal, and into the muscles and joints. Patients are categorized as mild, moderate or severe hemophiliacs in accordance with the amount of clotting activity they have.

TREATMENT

There is a vast difference between care 15 years ago and today. Then, school children and employees were often absent because they needed medical attention. Today, the preferred method of treatment is intravenous infusion of the factor concentrates to stop the bleeding. Since current management encourages self-care, a child can stay in school, be temporarily excused, infuse factor, and come back to class. An employee can remain at work and do the same. Thus, with

increased responsibility for his own health, education for the patient must be a vital, integral aspect of hemophilia care. Family members must also be educated since home care is emphasized.

If a hemophiliac needs medical attention, he may go to one of the 24 HSA federally funded comprehensive care centers in the United States, or to one of the 100 or so other hemophilia centers. In compliance with federal regulations, the federally funded centers offer a multi-disciplinary comprehensive treatment approach. The various team members represent relevant facets of the teaching, such as orthopedics, genetics, mental, and dental care.

EDUCATIONAL RESOURCES PROJECT

The National Hemophilia Foundation (NHF) is the only national health agency within the United States concerned with hemophilia. Its Nursing Committee made involvement in the creation of patient education programs and materials one of its goals beginning in 1978. At that time there was recognition that no centralized or systematized hemophilia education program existed in the United States. Need for guidance in educating patients and their families has been expressed both formally and informally. The need to assess the state of hemophilia education for a variety of target populations (e.g., health care providers, consumers, school personnel, vocational rehabilitation counselors, and legislators) was capsulized in a proposal submitted by NHF in partnership with the New England Comprehensive Care Center to assess the state of the art, identify educational needs, and begin to fill the gaps. The proposal was funded through the Office of Maternal and Child Health initially for one year. This was the beginning of the Educational Resources Project.

Two surveys were conducted nationally in 1979 among the treatment center

staffs of 98 centers and among 50 NHF chapters (consisting of patient and families). All phone and mail requests made during 1979 were recorded. The results revealed a desire for a centralized resource and information center, patient and family education - both printed and audio-visual materials, focusing primarily on home care, infusion, orthopedics, genetics, sports and exercise. The treatment center survey also revealed that the nurse coordinators wanted more educational skills and methods. In addition to beginning the creation of a National Hemophilia Clearinghouse, and an Educational Resources List (which was published in July 1981 listing all known Hemophilia Materials in the United States by source and subject), efforts were begun in conjunction with the Education Resources Project (ERP) Task Force of the NHF Committee to develop an educational package that could be used to guide providers in educating patients and families.

The Educational Resources Project received federal funding for two more years in order to accomplish this process which has been implemented in accordance with health education philosophy and methods. Participation in the creation and evaluation of the various components of the Patient/Family Model has involved joining input from a broad spectrum of providers: 11 Treatment Centers and their staffs: physicians, nurse coordinators, dentists, hematologists, genetic counselors, physical therapists, etc., health education specialists, the NHF Mental Health Committee and Social Worker Sub-Committee; as well as three patients and their families, and NHF consumer board members. The model has gone through three drafts. The fourth version is currently being used in all of the federally funded centers for a final program and process evaluation. The need for a teaching guide has also been expressed at the World Federation of Hemophilia Conference.

Future funding has been sought to continue training providers in the use of the Model as well as printing and distributing the Patient/Family Model both nationally and internationally.

Mr. Delson: Speaking from the point of view of a hematology nurse clinician, I'd like to stress that the original concepts for the Educational Resources Project were a natural offspring of nursing theory: A holistic approach to patient care, promoting optimal wellness and independence. Through patient education in a chronic illness such as hemophilia, acceptance and adaptability is fostered, as well as compliance with prescribed regimens.

Most of the nurse clinicians involved in the project, and on the Nursing Advisory Committee of the National Hemophilia Foundation, had developed teaching materials for use at their own centers. Although the project members came from all over the United States, there were marked similarities in the individually developed educational program, suggesting certain commonalities in learner objectives.

SEVEN MODULES

We recognized early in the project that it was essential to incorporate basic educational theory into the Patient/Family Model, such as the type of teaching methods, the format of the materials, behavioral objectives, selectivity and depth of information, assessing learner readiness and teacher effectiveness. The model consists of 7 teaching modules with pre- and post-tests, drawings and a list of resources. The modules are: Basic information - living with hemophilia, hemophilia family guidance, hemophilia factor replacement therapy, hemophilia home therapy, training and genetics education. The basic information or survival module was meant to provide the minimal level of knowledge necessary

for a rudimentary understanding of hemophilia. It also covered data on the recognition and management of acute problems common to this disorder. The home therapy module provided for instruction and practice in the skills necessary for intravenous infusion of factor replacement materials.

TEACHING OF THE MODULES

In practice, the teaching of the modules is a shared responsibility with overlapping of functional areas among team members. The dental module, for example, might be administered by the Dental Hygienist, Dentist or Nurse, depending on the time constraints and the existence of personnel making up the 'hemophilia team' which varies at different centers. At our center we have a genetics counselor available to counsel families on their genetic risks and options, and we jointly share the educational responsibilities for the genetics module. Centers not having this team member will have that function fulfilled by the nurse, social worker or physician.

Our greatest concern in designing the Patient/Family Model was the potential risk of creating a tool that was too rigid to be adapted to the needs of individual patients or the philosophy and composition of hemophilia teams at different institutions. The safeguards we employed included keeping the concepts basic to the behavioral objectives, without adding superfluous and subjective information. The feedback we have received thus far indicates we were successful in this objective.

COMPLIANCE

The importance of comprehensive educational programs as an integral part of chronic illness management cannot be overemphasized. Too often we underestimate the comprehension and motivation of our clients. The 'difficult'

patient who doesn't follow a prescribed therapeutic plan often doesn't understand what is to be done or why, not because of limitations in his intelligence, but due to the ineffectiveness of the practitioner's teaching. I have seldom obtained compliance from patients and parents solely because I told them the intervention was good for them, especially with adolescents; however, when patients are provided with all the information related to the therapeutic plan and are involved in its development, compliance is markedly increased. Ms. Forster, you have an extended background in nursing, but are new to the nurse clinician's role in hemophilia management. Please comment on your experience with using this already packaged educational tool.

The nurse clinician who has been in the field of hemophilia care for an extended period of time can call on experience which is gained through trial and error over a period of years. This more traditional educational process has undoubted merits and pitfalls. By applying a technique gained from the combined experiences of many workers in the field, a uniform module has been developed which allows a neophyte, like myself, to enter the field of hemophilia care to deliver good, coherent teaching, thus bypassing many of the pitfalls which were previously encountered.

ADVANTAGES OF USING THE MODULES

Before the teaching modules were instituted, there were few written guidelines for the nurse to utilize. At times, the amount of material to be taught appeared overwhelming, and one was never sure when the appropriate team members should be utilized to offer their own expertise.

With the development of the patient family model, the nurse can follow a systematic approach to health care teaching. It provides up-to-date knowledge,

and allows comprehensive coverage of the subject matter, presented in a flexible manner. Not every patient can be taught every module. They must be modified to fit the particular educational levels of the patient. These sets of modules provide the nurse with a basic starting point from which he or she can tailor each lesson to meet the goals of an individual patient as well as a particular teaching style.

In the past, even when teaching sessions went well, it was difficult to guage when a patient's desire to please the teacher with affirmative answers reflected a true understanding of the material presented. Using the pre- and post-tests that have been developed for each teaching module, I now have been able to define parameters with which to measure my patient's comprehension of a particular subject matter before proceeding to the next lesson.

Another benefit of the patient/family model is the enhancement of our own team's interaction. At Mount Sinai Hospital the dental hygienist, geneticist, and social worker now have an improved, well-defined role in the education of patients and families. The staff members, together with each patient, now plan the appropriate implementation and assessment of each module. I have found that since I have been utilizing the patient/family model my patients have shown an increased understanding of their disease, have been treating their disorder more appropriately, and have become more active participants in implementing their own medical care. And perhaps most important, they are also more aware of the emotional aspects which affect and interrelate with their physical illness.

SELECTING AND USING PRE-PACKAGED HEALTH EDUCATION PROGRAMS

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Opportunities and pitfalls in selecting pre-packaged educational programs are carefully explored in this paper. The need for realistic expectations of products is emphasized and steps in using them are reviewed.

INTRODUCTION

Imagine this scene in a busy dental clinic: A product salesman comes in one day with a "talking box", the kind which plays automatic movie cassettes. It shows kids how to brush their teeth on a seven-minute reel that repeats itself over and over. The salesman convinces the dentist and hygienist that the talking box will solve the dental problems of their young patients, and offers to leave it for a few weeks as part of a promotional effort. He places it on a table in the clinic waiting room, turns it on, and departs. The next day, several adult patients display mild interest in the film for about three minutes, and then go about their business. By the second day, no one takes any notice of the box. On the third day, several children start throwing paper airplanes at the box. On the fourth day, a three-year-old throws a large ball at the talking box. It falls over breaking both the movie cassette and the box. So ends one "health education" program.

Now let's move to a large hospital pharmacy where the pharmacist has ordered some pamphlets on drug interactions. He receives thousands of them, and so decides to put them in all the racks in the pharmacy waiting room. He then retreats behind the counter to fill and dispense prescriptions. Some parents take the pamphlets down to let their impatient children scribble on them. The children scatter the pamphlets around the waiting room. After the pharmacy closes for the day, and the pharmacist and all the patients have left, a custodian arrives to clean the waiting room. Seeing the scattered pamphlets, plus the remaining ones in the racks, he decides to make his own job easier. To prevent the recurrence of the problem, he throws all the remaining pamphlets into the trash bin. Another health education program is over.

Another example takes place in a general medical clinic. As usual, there is a long wait to see the doctor. The staff has managed to get a donated TV monitor. It is placed above the receptionist's desk, so it won't be broken. Usually, it plays soap operas, which seem to make the patients a little bit less cranky. One day, someone from the clinic's back-up hospital suggests that the clinic not "waste the patient's time" with soap operas, but rather play three health education programs which the hospital happens to own. The programs, which are on videotape, last about ten minutes each, and play continuously on the monitor. On the first day, there is some interest the first time the tapes play, a little less the second time, and almost no interest by the third go-round. By the end of the week the patients are quite edgy and are becoming abusive towards the receptionist. Worse, the rate of broken appointments starts to go up. Was this the effect of the videotape programs?

I think that everyone would agree that these were unsuccessful health educa-

tion efforts. Each of the pre-packaged materials described could have been part of a good health education program, but were not used to best advantage. In fact, they were used to the worst advantage! In this paper, I will discuss some of the ingredients which go into the successful use of pre-packaged programs.

IDENTIFYING THE PROBLEM

At the outset, I'd like to emphasize that the health education process is a problem solving process. To make it work, one must first identify the problem. To give a few examples from various settings: "There are too many patients in this clinic whose blood pressure is not controlled." "We have too many broken appointments in this general medical clinic, so we can't plan our staffing very well."

"Too many patients come to this Health Maintenance Organization with minor problems which could be treated at home. Our costs are going up, and we waste staff time."

In each case we should first ask ourselves: would a change in behavior help solve the problem? The answer in all three of the examples is yes, within realistic boundaries.

Sticking to a prescribed medication regimen will certainly help control a patient's blood pressure. Of course, not all patients are now on the optimal medication regimen, so 100 percent of them will not be controlled by the behavior change alone.

Calling the clinic 24 hours ahead to cancel an appointment will certainly help with staffing and scheduling problems. Of course, not everyone knows a day in advance that the appointment will be broken. And even if all the HMO

patients learn the signs and treatments of minor injuries, there will still be some grey areas requiring a visit to the doctor or nurse.

However, we can say that given realistic goals and expectations, each problem is amendable to a health education solution.

SELECTING COMMUNICATION STRATEGIES

Next, we must find a way to communicate the information, skills, and attitudes needed to help patients accomplish the pinpointed behavior change. What strategies do we have available to do this? Common communication strategies include the use of pamphlets, posters, films and videotapes.

Writing a pamphlet sounds like the simplest. As anyone who has ever produced a good pamphlet will tell you, it involves, at a minimum, writing the text, editing, illustrating, rewriting, re-editing, printing and assembling. What about making a movie? If writing a pamphlet is a complex process, think about the effort involved in making a movie - and about the kind of results one usually gets without access to professional equipment and training.

These examples serve to illustrate the difficulties involved in creating health education program materials from scratch. They demonstrate why the answer is often to use a pre-packaged program, that is, any program or material made outside one's own agency. In many situations, pre-packaged programs may well be the easiest, fastest, cheapest, most effective way to meet your goals and objectives. Compared to homemade efforts, these programs are often better made, better tested, more carefully refined, more acceptable, easier to use, come with back-up support, and, if very well-made, come with built-in evaluation procedures.

ESSENTIAL STEPS IN THE USE OF PRE-PACKAGED MATERIALS

Here are five steps which help assure that the best use will be made of pre-packaged health education materials: 1) Find; 2) Test; 3) Adapt; 4) Implement; 5) Evaluate.

Let's see how these steps take place in a common situation, a hypertension clinic. We know the problem, "too many of our patients' blood pressure is uncontrolled, due to lack of compliance with diet and medication regimens." Since we know our clinic population, we know some facts which may help us in the program planning process: the typical educational level, age and sex distribution, and ethnicity, for example. We choose to conduct our health education program in the clinic setting because here we have a captive audience, who routinely come to us for medical and counseling services. Although there are many others who do not attend our clinic who have the same problems, it would require a much larger effort to reach them. So we begin with those closest to home.

Our objectives for the program will relate to the individual behavior changes involved in taking medications and sticking to prescribed diets, since these behavior changes have been shown to be efficacious in reducing high blood pressure. The range of communication strategies which we will employ may well include some or all of the following: posters, pamphlets, films, and group and individual counseling sessions. Pre-packaged materials are available in all of these areas except counseling. (Don't let anyone fool you! You can't package counseling. It can only be done by live, trained professionals such as social workers, nurses, psychologists, health educators, physicians, pharmacists, etc.)

Finding Materials

The first question you probably have is how do you find all those wonderful pamphlets, posters, filmstrips, films or other pre-packaged materials? The best place to start is with some annotated bibliographies or catalogues. These are often available from national clearinghouses related to health education, health promotion, or to a specific health issue such as hypertension or diabetes. Other good sources for bibliographies are voluntary health agencies, pharmaceutical and insurance companies, state and local health departments and libraries. In addition, there are a growing number of commercial companies which specialize in written and audio-visual health education materials. When contacting these agencies, always ask for a catalogue with descriptions, not just a list of titles. Most catalogues will specify the age, sex, educational level, and other characteristics of the audience for whom the materials are most appropriate.

Testing Materials

You've written letters to all these agencies and, three weeks later, you find yourself deluged by films, pamphlets and posters. Now is the time to examine all these materials - and test them out.

Who should examine them? You, your staff, practitioners, patients, community residents, and administrators, should all have a chance to look at potentially useful materials. The following qualities should be among those which are evaluated:

* Appropriateness: Crew cuts show a film to be dated.
* The message which is delivered: If your agency disapproves of a treatment modality, it will only confuse patients to see it advocated in a filmstrip.

* Interest and appeal: A dull film is worse than none at all.
* Use of language: Language that is too technical may be medically correct, but will confuse and even alienate patients. A patient with a graduate degree may be no more knowledgeable about his disease than one without a high school diploma.

Adapting Materials

The next step is a critical one for programs created outside your agency. Any pre-packaged program must be adapted to your population and your organization if it is to succeed.

For example, in bringing a "stop smoking" program to a local health agency, other staff members and I had to choose among three complete and well-tested programs. We had to determine which one could best be adapted to our agency's needs. We spent several evenings observing sessions of each program before deciding which one could be most easily adapted to our setting.

A well-known commercial program had all the right components, but we felt the cost to participants, about $250, would be beyond the means of our lower-middle class population. A program sponsored by the Seventh Day Adventist Church was also well-conceived and well-run. However, we felt that as a public agency we should not co-sponsor a program with a religious group. In addition, the program was condensed into one week and we felt it would sound too much like "cold turkey" to our prospective participants.

So we chose, instead, the program sponsored by the American Cancer Society, which has very high credibility in the community. Its timing, six to eight weeks to complete the program, was good; the excellent back-up provided by the American Cancer Society included staff training, written and audio-visual materials, and

even built-in evaluation and follow-up components.

As an added benefit, we were able to further our agency's general goal of being seen as serving the entire community by holding the "stop smoking" program in a prestigious local club house.

Implementing the Program

After the program has been adapted to your setting, you are ready to implement. When making your schedule for implementation, do not forget to budget the time and other resources for:

* staff training,
* recruitment of volunteers when needed,
* travel and other costs involved in borrowing "free" materials.

You should always keep in mind that donated resources are not really "free". Think about the costs of using free space. Someone pays the taxes on it, someone pays the rent. The heat and lights appear on some agency's account. Someone has to open the door, close the door, and clean up before and after the program.

Evaluating the Program

Now you're done, right? Not quite yet! The final step should always be the evaluation of the program. By evaluation, I don't mean "heavy duty" research. Just a simple investigation to find out whether the program accomplished what it set out to do is fine. Try to use simple techniques involving records which are readily available. For instance:

* Do patient medical records show blood pressure to be under better control now?
* Are fewer broken appointments noted on the clinic log?
* Does a ten question pre- and post-test show that people now recognize

minor medical problems which can be treated at home?

There are two reasons why the evaluation process is so critical. First, staff needs feedback about the results of the time and effort they spent on the program. They may, for example, feel badly that only half the people in the program stopped smoking. Since the average percentage of participants who stop smoking in such programs is only 20 to 30 percent, the staff should know how successful they were. Secondly, the agency's administration allocated resources such as money, space, and staff time to the program. If you can demonstrate that the program met its objectives, and that the identified problem was solved, you will be much more likely to receive those resources in the future.

In conclusion, I'd like to say, that if you can, avoid falling into these traps and pitfalls:

"Do the health education program first, you can always think of the goals later."

"This health education package will solve all your problems, just follow the directions."

"This health education program is good in any health care setting; it needs no special knowledge of the target population."

"You will certainly need this sophisticated audio-visual equipment to do a good health education program."

Then using a pre-packaged program can often be the easiest and best route to conducting a successful health education program.

PREPARING FAMILIES TO HELP OLDER PEOPLE

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This speaker chose not to submit a written paper for the proceedings. The editorial committee, however, has listed these important concepts from her presentation.

* This is a description of a project funded by the Department of Health and Human Services Administration on Aging, and conducted at New York University.
* The purpose of the project was to provide resources to the community, especially to those people who were serving as care-givers for the elderly.
* The method used to provide this support was to send nursing students, social work students and medical students into the community to: help educate the care-givers about health topics; and to provide a support group for these care-givers, most of whom were themselves elderly.
* A needs-assessment was conducted, and a curriculum devised based on the needs assessment. Medical experts from New York University Medical Center helped to create the curriculum.
* Topics covered were general health education, basic anatomy and physiology, legal-medical issues about care-giving, consumer information related to medicine, issues related to aging including agism, and disease and treatment of disease.
* The education groups evolved to self-help groups in three of five instances, and they continued in existence after the funded project ended.

* The outcomes of this project included:

  a. development of a health education guide for the elderly

  b. development of a patient-advocacy video-tape to help raise the consciousness of health workers about the problems of aging

  c. continuation of three self-help groups.

PROJECT UPBEAT: A MODEL FOR CARDIAC PATIENT EDUCATION

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This paper examines education about a serious chronic disorder, heart disease. In addition to using an expert multi-disciplinary panel to determine content, the project features a strong program of staff training prior to its implementation. The model is versatile and may be adapted for dealing with other chronic conditions.

OVERVIEW

In 1972 the Office of Consumer Health Education was established at the University of Medicine and Dentistry of New Jersey through a grant from the Hunterdon Health Fund, a private foundation in New Jersey, to design a program that would utilize community hospitals in New Jersey to provide consumers with health education. The model was established for both in-patient and community health education programs.

As the staff at the Office of Consumer Health Education (OCHE) worked with the hospitals selected for the demonstration program, it became evident that there was a need for structured educational programs that were evaluated for effectiveness but also had flexibility so that they could be adapted to a variety of hospital settings.

Consequently, the OCHE staff developed a proposal that was funded by the Prudential Foundation through the Foundation of the College of Medicine and Dentistry of New Jersey for the project that was to become known as Project Upbeat. The content area selected for program development was myocardial infarction although it was believed that the approach used would be applicable to the development of programs for other diseases as well.

CONCEPTUAL FRAMEWORK FOR PROJECT UPBEAT

Over one half million people annually survive an acute myocardial infarction.(1) While much has been written on the possible causes of a myocardial infarction and physiological and psychological responses in the coronary care unit, very little has been written on how to prevent recurrence of a myocardial infarction. It is known, however, that many people who have had an MI exhibit signs of anxiety and depression in the hospital and in the post-hospital recuperative period.(2,3)

Also, it has been shown that MI patients who are emotionally distressed have a very low rate of recuperation and a very high rate of recurrence of an MI. Many studies have cited that most depression and anxiety results from fear of another heart attack caused by engaging in over-activity.(4,5) This fear begins a cycle of either early retirement or lower output at work, decreased sexual functioning, and even total withdrawal from daily life routines which then increases depression and anxiety and continues the cycle.

How can the cycle be broken? Many strategies have been proposed, including educational programs for the MI patient in the hospital period, post-hospitalization groups geared to stress management, medications such as antidepressants, exercise programs designed for the MI patient, and post-hospital sharing and caring groups.

Very little has been systematically evaluated however, as to the effectiveness of such treatment in decreasing the depression and anxiety and increasing the rate of recovery. This program is designed to do so.

DEVELOPMENT OF THE TEACHING PROGRAM

A panel of experts was assembled in order to define the essential content areas for each component of the program. The advisory committee was composed of individuals with expertise in cardiac nursing, nutrition, exercise physiology, stress management, patient education, epidemiology and vocational rehabilitation. Based on their expertise, decisions were made regarding the content of the teaching plan which was designed to provide for continuous education, reinforcement, and rehabilitation beginning in the hospital and extending after hospitalization to the home.

Throughout the teaching plan, the focus is on the patient and family and encourages active participation by them in order to work through lifestyle adjustments that may be required. Patient input is sought because although adjustments in the level of activity, type of diet, sources of stress and appropriate types of exercise may be recommended by the hospital staff, the patient will have to carry the changes out.

THE TEACHING PROGRAM

Project Upbeat is divided into two phases: in-patient and post-hospitalization.

In-Patient Program

The in-patient program consists of six sessions and begins with an orientation to the coronary care unit (CCU) by the CCU nurse. She decides when the patient is ready for this educational experience, which usually occurs somewhere between the second and fifth days following admission. The main areas covered are

diagnosis counseling and a description of the CCU procedures and equipment. These topics are covered in a pre-test taken by the patient. The nurse assesses the results and teaches only about areas where there is lack of knowledge. As this and all subsequent teaching takes place, the elements of each session covered are entered on the teaching summary sheet by the person who conducted the teaching experience. This may be the CCU nurse, pharmacist or dietitian. The teaching summary sheet then becomes a permanent part of the patient's chart.

The second session of the teaching plan is carried out on the first day after discharge from the CCU. During this session, the nurse performs a patient/family assessment. The assessment probes for feelings about the myocardial infarction, previous knowledge of myocardial infarction, pre-existing health benefits, self-care abilities and learning preferences. A standardized form is used by all staff nurses to collect this information. This is also the appropriate time to begin discussion of the patient's condition, identify stress factors, care in the unit and the goals of the in-patient program.

By the sixth day of the hospital stay the patient is ready to begin to learn about coronary artery disease. This third session is conducted by the nurse in either a one-to-one discussion or in a group, depending upon the facilities available and the number of patients who are ready for this teaching experience. At this time the discussion centers on the heart muscle, different forms of the disease, the healing process that has to take place and the risk factors that may increase chances of having another heart attack.

The dietitian is responsible for the fourth part of the teaching plan. Nutrition is taught throughout the hospital stay. The teaching material is divided into two components. The first area is an outline for patient teaching

for the dietitian's use which focuses on such items as diet modification, the role of diet in the recovery process, exchange lists and meal planning, food selection, lifestyle changes relating to diet, reading food labels and discharge planning. The second part of this unit is background information for nurses on diet restrictions to assist the nurses in answering questions between visits by the dietitian.

By the 9th to 13th day of the patient's hospital stay, the nurse discusses pre-discharge information with the patient. Again, depending upon the facilities and the number of patients, this may be either a one-to-one or a group session. Discussion areas include: activity and exercise, how to take a pulse, what to anticipate when the patient goes home, and tips regarding future activities, including sexual ones.

The last session is devoted to discharge planning which takes place, of course, just prior to discharge from the hospital. This is the time to review the physician's orders, including medications, activity, diet and special instructions. The medications can be reviewed by the nurse, the pharmacist or a pharmacy student. The diet instructions ordered by the physician should be explained in detail by the dietitian.

Other areas to be covered by the nurse prior to discharge include information about warning signs of a heart attack, lifestyle management, hobbies, the supportive role of family and friends, community resources including an invitation to attend the post-hospital program if there is one in the area, and the optional follow-up card containing the name and phone number of the nurse should the patient or family have questions after discharge.

As the patient participates in each of the sessions, relevant teaching

materials are provided. The materials are taken home in a packet on discharge day.

It is when patients return home following treatment that questions and concerns really begin to surface. Changes in lifestyle recommended by the physician often mean adjustments for both patient and family. Because these adjustments are often similar for many patients, an educational program was organized at the hospital for patients and their spouses or significant other.

Patients are invited to join the group program approximately six weeks after their discharge from the hospital. For some patients this is too early, and consequently they will not respond to the invitation to attend until they are ready. The post-hospital program has been named "Lifestyle" at the John F. Kennedy Medical Center, Edison, New Jersey, and requires a nominal registration fee to cover some of the costs of the six-session program.

The first session of the post-hospital program is designed to orient participants to the post-hospital program and to help them share experiences regarding their heart attack and the recovery process. For some people this program may be their first experience as a group participant, so this session is designed to assist patients and their spouse/friend to feel comfortable speaking in a group and expressing feelings and ideas about their experiences while in the hospital and at home.

Either a nurse or social worker serves as facilitator for this session as well as the ones that follow. The facilitator decides whether to invite specialists to address specific content areas in subsequent two hour sessions.

Normal functioning of the heart as a framework for understanding the pathophysiology of a myocardial infarction is the focus of the second session.

Stress is discussed in terms of its physiological effect on the body. Risk factors are reviewed and lifestyle changes due to risk factor modification are discussed. Participants are encouraged to express their frustrations and successes in making the recommended lifestyle changes.

The third session begins discussion of specific medication and activity regimens. Topics covered are: medications prescribed; purpose and precautions; incorporating MEDS into a daily routine; compliance; activity regimens, purpose and precautions; incorporating activity into a daily routine; and the interaction of MEDS and activity. The pharmacist or an exercise therapist makes an appropriate guest speaker for the session.

Review of restrictions relating to behavior change that have been ordered by the participants' physicians are continued in the fourth session. The purpose of this session is to identify adjustments, lifestyle changes and stresses that the participants and their families will be managing and to consider how these changes can be accommodated. Topics for discussion include: dietary modifications; purpose and effect on health of the heart; basic nutritional information; changing eating habits through behavior modification; meal planning and food substitutions; reading food labels; eating out; and community resources for risk factor modification. A dietitian and a behavioral specialist are invited to this session, but again it depends upon the expertise of the group leaders as to who may be needed as additional faculty.

The fifth session is devoted to information and practice of relaxation techniques designed to alleviate the effects of stress. The sessions begins with a discussion of stressful events that frequently result from a myocardial infarction such as role changes and financial problems. The group is then

introduced to various relaxation techniques and encouraged to practice them during the session. Specific topics include: stress as it relates to the recovery process; changes in the family as a result of the MI; stress associated with the return to work; and relaxation techniques.

The topic for the final session is left open until the needs of the participants are assessed. The project staff believes flexibility to pursue a topic of special interest and concern to the group is very important for the group process. Possible topics are: smoking and other behavior changes; sensitivity and marital counseling; family participation in a group session; dealing with depression; and coping with financial changes.

IN-SERVICE TRAINING PROGRAM

Before the in-patient program and post-hospital program were implemented, an in-service program was held for the hospital staff who would be involved with Project Upbeat.

In-Patient Program

The in-service program for the in-patient program at the hospital consists of four, three-hour sessions conducted by a multidisciplinary team. The first session begins with an overview and history of Project Upbeat including the administrative approval process that must take place at the hospital before a new program is implemented. In addition, the teaching program is reviewed, as well as the category of professional responsible for the various sessions. The purpose of this training session is to acquaint the staff with the curriculum and to teach the staff how to use the program.

The second session emphasizes how to access the patient's readiness to learn and to provide the opportunity for the nurses to practice the assessment

through role-playing techniques. Case histories were developed for the role-playing session.

Improving communication techniques and teaching effectiveness are the goals for the third session. Following a didactic session regarding basic communication skills, participants divide into pairs for the communication exercise and role-playing experience.

A panel of experts is invited to the fourth and last session to provide a forum for staff to discuss major issues in teaching and caring for patients. The panel contains representatives from nursing, medicine, pharmacy, social work, dietary and patients. Through this multidisciplinary panel, the roles of the health care team members are emphasized. This session also provides the participants with the opportunity to discuss practical issues such as "how do you determine risk factor priorities when you know one person can't realistically change all factors at one time?" At the close of this session, each participant receives a certificate documenting participation in the in-service program.

Post-Hospital Program

The in-service program for the post-hospital program consists of one, four hour session. The primary goal of this session is to train the nurses and social worker to serve as group facilitators for the post-hospital programs. Since the post-hospital program may utilize an expert in the content area, the primary function of the nurse or social worker is to serve as a group facilitator and to be responsible for the operation of the program.

EVALUATING THE PROGRAM

Two hospitals in New Jersey, John F. Kennedy Medical Center and Middlesex General Hospital have served as demonstration sites. In addition two other

hospitals in New Jersey, Perth Amboy General Hospital and Muhlenberg Hospital, served as control hospitals. Data were collected at these hospitals at the same point in time; as the demonstration hospitals, however, Project Upbeat was not implemented at the control hospitals. The control hospitals conducted their patient education in their usual way.

I would like to close by just mentioning the major hypotheses tested during the evaluation of this model:

* Knowledge: The demonstration group will show a significantly higher post-test knowledge score than the control group.
* Anxiety: Demonstration patients will show greater decrease in anxiety at six months than the control patients.
* Depression: There will be significantly less depression in the demonstration group than in the control group at six weeks and six months after discharge.
* Health Practices: Demonstration patients will have significantly higher health practice scores than control patients at three months and at six months after discharge.
* Compliance: Experimental patients will demonstrate greater compliance than control patients at three months and six months.
* Return to Work: The demonstration group will return to work in significantly fewer days that the control group.
* Length of Stay: The demonstration group will be hospitalized for significantly fewer days than the control group.

The data collection for this project will be completed in January 1982. By this date next year, it is our hope that this teaching plan will:

* Provide hospitals with a standardized approach for teaching myocardial infarction patients;
* Provide a plan of educational rehabilitation for myocardial infarction patients beginning in the hospital and extending after hospitalization to hasten recovery, promote constructive lifestyle modification, and facilitate return to home and/or work; and
* Provide a strong base for third-party reimbursement for patient education services.

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REFERENCES

1. National Heart and Lung Institute. Task Force on Cardiovascular Rehabilitation. Needs and Opportunities for Rehabilitating the Coronary Heart Disease Patient, U.S. Government Printing Office. DHEW Publ. No. (NIH) 75-750 (December 1974).

2. S.H. Croog and S. Levine. The Heart Patient Recovers: Social and Psychological Factors, New York: Human Sciences Press, 1977.

3. H.A. Wishnie, T.P. Hackett and N.H. Cassem. "Psychological Hazards of Convalescence Following Myocardial Infarction," J.A.M.A., 215(8): 1292-1296.

4. A. Wynn, "Unwarranted Emotional Distress in Men With Ischaemic Heart Disease (IHD)," The Medical Journal of Australia, 2(19): 847-851, 1967.

5. M.G. Miller and J. Brewer. "Factors Influencing the Rehabilitation of the Patient With Ischaemic Heart Disease, " The Medical Journal of Australia, 1(8): 410-416, 1969.

PINPOINTING THE MESSAGE TO ACHIEVE COMPLIANCE

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This paper examines the special requirements for teaching patients suffering from acute communicable diseases. Suggestions for developing and refining specific messages for different stages of treatment, staff training, and the role of the exit interview in determining the client's level of understanding are described.

INTRODUCTION

I would like to share with you some of my experiences in setting up a patient education program for venereal disease patients in the New York City Health Department.

The ultimate goal of a good patient education program is to develop two-way communication and decision-making on the part of the patient, leading to voluntary behavioral changes based on informed choices. Telling patients not to have sex or teaching them how to use a condom is a little different from telling them not to smoke, or to stay away from eggs or that extra piece of Boston cream pie. So, before we started conveying messages to our patients, our first concern was to define our target population and determine the specific needs of the clients.

The venereal disease patient is no different from any other type of

patient. Our clinic patients are from all socio-economic groups and of all ages. Our target groups were defined solely by the disease they were diagnosed as having. For example, gonorrhea patients would receive different information from a patient who had a case of herpes genitalis. We also conducted, prior to developing any "messages", an assessment of what our patients were already receiving in the way of information. We did this through a technique known as "exit interviews". This is where patients are asked a series of questions upon completion of their visit. The questions were designed to see if the patient understood the nature of his or her infection and to determine their understanding of what is expected of them in curing this case of venereal disease.

With this understanding of what our patients knew or did not know, our second concern was to set up training for our clinic staff. A good patient education program must enlist the active cooperation of the total clinic staff. Doctors, nurses, clerks and all other personnel who have contact with patients should be made responsible for the delivery of at least one key message (e.g., the doctor may want to emphasize to patients the need for keeping future appointments). This strategy will help to reinforce material presented during the counseling session. Visual materials such as posters, slides, and videotapes shown in the waiting rooms can also help to reinforce key messages.

Staff training was a two-phased operation which attempted to accomplish the following: First, it provided specific and current information on the management of sexually-transmitted diseases. Second, it developed specific skills to enable the staff to implement a patient education program.

In the first phase, detailed information about diagnosis, treatment, and

follow-up of all sexually-transmitted diseases was given to the staff to help upgrade their ability to manage these disorders. This training was conducted by the staff in my office.

The second phase of the training program attempted to develop skills in the clinician which are necessary to properly implement a patient education program. The intent here was to sensitize the staff to the complexity of patient behavior and to show how the staff's own attitudes and beliefs affect their relationship with patients and their expectations of patient behavior.

Regular meetings involving the entire clinic staff were scheduled. These meetings focused on staff training as well as generating policies for the smooth and efficient operation of the venereal disease program. Policies ranging from developing patient literature to the publicizing of clinic hours was discussed and formalized. It is the responsibility of each staff member to see that patients leave the clinic not only with the assurance of being cured, but in a state of emotional satisfaction knowing that their questions have been properly answered and explanations about their diseases have been properly addressed.

PROGRAM OBJECTIVES

The venereal disease education program is specifically designed to:

* Increase the number of referrals by patients to our clinics
* Increase the number of patients returning for test-of-cure for gonorrhea
* Reduce the repeater rate (those having syphilis or gonorrhea more than once in three months).

These objectives are simple and direct. More importantly, each is easily measured since we can count, on a routine basis, the increases or decreases for each one. This enables us to come to some conclusions about the relative

effectiveness of the program as well as how and if new dimensions of venereal disease education may be required.

CONTENT OF PATIENT EDUCATION PROGRAMS

The next phase of our patient education programs was the development of informational messages that would be imparted to the patient by the clinic staff.

Deciding on essential information was facilitated by a needs assessment of our patients. A difficulty arose in trying to minimize the essential while maximizing the impact of these messages.

Although the wording and illustrations of these messages may vary within different clinics or health care settings, we have found that any messages to a patient should have the following characteristics:

* messages should be honest and accurate
* messages should be simple and direct
* messages should be visually exciting, using good graphics with striking layout and color
* messages should be nonjudgemental and contain no moral overtones
* messages should be action-oriented couples with practical information about how and what to do.

In our venereal disease messages there are five specific components that a patient must understand, receive and act upon in order to deal effectively with a sexually-transmitted disease. They are:

1. Understanding the medical aspects of their infection
2. Understanding the need for complying with the instructions for taking medicine properly
3. Understanding the importance of treating sex partners

4. Understanding the value of follow-up treatment and testing

5. Practicing prevention techniques (risk reduction)

Counseling of Medical Aspects

In the early part of the counseling sessions, patients should be encouraged to know about their present infection and the counselor should reemphasize:

a. the name of the infection being treated; b. the recognition of early symptoms; c. the stopping of all sexual activity once symptoms are recognized or suspected; d. the importance of prompt, clinical attention to symptoms or possible exposure; e. the possibility of asymptomatic infections.

Counseling on Medication Compliance

Here the counselor should, in very brief and explicit terms, tell what the patient is to do or not do. Written instructions should accompany those that are verbal. This information must include:

a. name of the drug being used; b. quantity and frequency of drug usage; c. efficacy of the drug; d. symptoms and appropriate response to drug failure and side effects, i.e., foods and other conditions that should be avoided. It is important to also emphasize, if pills are to be taken at home, that not only should all the pills be taken, but they should be taken at the times prescribed in order to be effective. It is equally important to advise patients of any possible side effects they may feel and give the patient tips on how to manage their side effects without disrupting the treatment regimen.

At the end of this session, patients should be asked if they foresee any problem adhering to the treatment schedule and if so, why? Getting the patient involved in understanding what they will be taking and how they will respond adds to their belief in the effectiveness of this treatment.

Counseling on Treatment of Sex Partners

Here patients should be told:

a. how the disease is transmitted (anal, oral or genital contact); b. time period relevant to the infection (i.e., gonorrhea and syphilis); c. importance of sex partner referral; consequences of not referring partners, i.e., asymptomatic infections, ping-pong infections, possibility of patient becoming reinfected, and complication of untreated infections (couples).

A plan on how to contact and inform sex partners should be worked out between the counselor and the patient. Point out available options for contacting sex partners (phone, person to person, public health advisors). If the patient chooses to do his/her own referral, advise patients on how to do so by following the guidelines set down by the counselor. Assure patients that emotions which arise as a result of infection like anger, guilt, etc., are normal, but the priority is treatment of contacts.

Counseling on Risk Reduction

Patient should be told:

a. reinfection can occur; no immunity is conferred as a result of present infection; b. necessity of abstaining from sex until the tests are negative and sex partners have been treated; c. explain how to properly use the condom.

A plan for "risk reduction" or prevention of sexually transmitted diseases should be worked out between the counselor and the patient. This plan must take into account the lifestyle of the patient and what minor modifications the patient is willing to make in his or her lifestyle. If the modifications are too large, the probability of patient compliance becomes very low.

Strategies for risk reduction fall into two main categories: physical and

behavioral. Physical strategies are: 1) use of the condom, 2) washing genital areas before and after sex, and 3) visual inspection of partner's genitals. Behavioral strategies include: 1) reduction in the number of sex partners, 2) knowing sex partners, 3) limiting sexual activity to one partner, and 4) abstaining from sex.

A plan must be developed with the patient that is consistent with his/her lifestyle. Remember, for successful risk reduction, the patient must be willing to use the prescribed strategies.

Counseling on Follow-Up Treatment and Testing

Since it is often necessary for the patient to make a second or third visit to the clinic in order to complete treatment, it is important that reappointments are kept. Again, a variety of strategies may be used to motivate patients to keep reappointments. These include:

a. Informing patients why a second or third visit is needed; b. Telling the patient when and where these tests will be given. Always try to give the patient a specific date and time and ask the patient if they can keep it. If the patient cannot or is not sure, a new date may have to be agreed upon. Even if your clinic doesn't give appointments, it's a good idea to commit the patient to a specific time; c. Advising the patient to call and set up a new date if he/she cannot attend; d. Emphasizing to patients the potential consequences if reappointments are not kept; e. Mailing or giving letters confirming appointments may help remind patients.

EVALUATION

Over the past three years there has been an increase in the number of sexual contacts referred to our clinic by patients with all types of Sexually Transmitted

Diseases. Consequently, there has been a fifty percent increase in patients returning for their test of cure for all these diseases. Finally, the repeater rate, a person having a curable venereal disease more than once in three months, has been reduced by five percent.

CONCLUSION

Patient education programs are important for controlling sexually-transmitted diseases, as can be seen by the history of such disease control programs throughout this country. Venereal diseases are the only ones for which we have adequate diagnostic procedures and treatment schedules. Medically, with the exception of herpes, sexually-transmitted diseases can be controlled and cured.

The importance of therapeutic medicine, vital as it is, may have reached a point of diminishing return. People know they can be easily treated for venereal disease and they have ignored their responsibilities. It is because of this that we have intensified our patient education efforts. For without a patient's understanding of their direct involvement in the management of the disease, all the medicine in the world will be useless in controlling sexually-transmitted diseases.